Conversion and Preservation of Charitable Assets
of Blue Cross and Blue Shield Plans:
How States Have Protected or Failed to Protect the Public Interest
March 2004

Alaska

In May 2002, Premera Blue Cross of Washington and Alaska, which covers over one million people in both states, announced its plan to convert to a for-profit insurance company.

Initially, Premera proposed to set aside stock in a nonprofit "Foundation Shareholder" as part of its effort to convert to a for-profit. But the company did not detail how the value of the stock would have been established, or whether the value would have reflected important assets such as the value of the Blue Cross trademark, goodwill, the value of its contracts with providers, and its subscriber lists.

In February 2003, Washington Insurance Commissioner Mike Kreidler allowed over two dozen individuals and organizations asserting a “significant interest” to intervene in the conversion of Premera Blue Cross of Washington and Alaska. Several of the intervenors oppose the conversion of Premera, and have raised questions about whether the full value of the company would be preserved for the public if the conversion is approved.

In granting the motions to intervene, Kreidler grouped the intervenors into five categories and required each of the five groups to appoint a lead attorney. Each group will be treated as a single party for purposes of discovery, presentation of evidence, oral and written argument, and cross-examination. The groups include: Washington consumers, Washington hospitals, Washington providers, and a coalition in Alaska. Among the members of the Alaska coalition are the Anchorage Neighborhood Health Center, United Way of Anchorage, and the University of Alaska.

In February 2004, Premera filed its amended Form A with the Insurance Commissioners in both states. The Washington Insurance Commissioner will convene the formal adjudicative hearing on Premera’s conversion request in May 2004 and expects to make a final decision in the matter by July 2004. The Alaska Commissioner will hold hearings in June on issues relating to the transaction and to Premera’s proposals regarding the creation of a foundation.

California

Blue Cross of California (BCC) transferred a majority of its assets to a for-profit subsidiary in 1993. State regulators originally approved the transaction without any formal charitable asset distribution. Subsequently, the Department of Corporations determined that the transaction failed to protect the charitable assets of the former nonprofit corporation. The Department Commissioner entered into discussions with BCC. The plan initially proposed distributing $100 million of its assets to a charitable foundation. The Commissioner did not accept this figure. A series of negotiations ensued between the Department and BCC. Ultimately, BCC agreed to distribute all of its assets, over $3.2 billion, to two grant making health foundations, creating The California Endowment, a 501(c)(3) private foundation, and the California HealthCare Foundation, a 501(c)(4) entity. The regulator hired independent consultants for assistance with determining the appropriate valuation of the company and the mission, governance, and structure of the foundations. The charitable assets were distributed in a combination of cash and an equity interest in the new for-profit. The board selection for The California Endowment was extremely thorough and involved an executive search consortium.

The for-profit successor to Blue Cross of California is WellPoint Health Networks, Inc. In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a

definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

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Colorado

In January 1997, BCBS of Colorado (BCBSCO) filed a proposal to convert. Two weeks before filing the proposal, it merged with Nevada BCBS, forgiving $9.8 million in debt that the Nevada plan owed to the Colorado plan. [See Nevada below.] BCBS originally proposed to distribute 100% of the stock of a holding company to two 501(c)(4) foundations. In May 1997, the Colorado plan filed an amended plan of conversion after community representatives raised a number of issues about the original proposal. The amended plan proposed to distribute the net proceeds of an initial public offering of stock in a holding company to one 501(c)(3) foundation. A formal regulatory process ensued, where consumer groups were permitted to intervene and participate in the conversion approval process. Hearings to determine the mission, governance, and structure of a foundation created to receive the proceeds of the conversion occurred in 1997. The Caring for Colorado Foundation was thereby established, with a community advisory committee. The hearing process to determine the value of BCBSCO never occurred. Instead, in June 1998, the plan moved to postpone the conversion altogether.

In March 1999, BCBSCO announced that it was withdrawing its proposal to convert itself to a for-profit stock company. Immediately thereafter, BCBSCO announced that it was planning to "affiliate" with Anthem Insurance Companies, Inc. [See more on Anthem in Kentucky, Ohio, New Jersey, Connecticut, New Hampshire and Maine below.] Anthem agreed publicly to set aside at least $100 million in a nonprofit foundation.

As part of the plan to affiliate, BCBSCO entered a surplus note agreement that would allow Anthem to earn millions from BCBSCO's nonprofit dollars if BCBSCO ultimately decided not to affiliate with Anthem. Included in the terms were the following: an increase in the interest rate BCBSCO would have to pay Anthem on the original loan, a break-up fee of $6 million that BCBSCO would have to pay to Anthem and, if BCBSCO were to pull out of the deal by going with a company offering a higher bid than Anthem, BCBSCO would have to give Anthem half of the difference it obtained from the higher bid. Consumer groups were highly critical of these conditions. In order to complete the affiliation, on August 16, 1999, Blue Cross and Blue Shield of Colorado) filed a new application to convert to a for-profit. This time, Anthem offered $155 million and promised to preserve at least $140 million of the purchase price in the Caring for Colorado Foundation.

The proposal was filed on the heels of an announcement by Wellpoint Health Networks, Inc. (the for-profit successor to Blue Cross of California) to withdraw an earlier offer to buy BCBSCO for

$266 million, $111 million more than Anthem's offer. Wellpoint promised $10 million more to the foundation. WellPoint withdrew its offer when BCBSCO failed to answer whether it was going to enforce Anthem's onerous breakup provisions included in its surplus note agreement.

During this process, Governor Bill Owens unraveled an earlier administrative decision approved by the former Insurance Commissioner, Jack Ehnes, that the foundation's by-laws must include a Community Advisory Committee (CAC). Consumer groups involved in the conversion had pushed hard for a Community Advisory Committee and had testified at the 1998 public hearings held by the Department of Insurance. Governor Owens requested that the foundation's Board of Directors change the by-laws to give him the power to appoint directors without any community process. The new by-laws effectively dismantled the Community Advisory Committee's role in ensuring that the board nomination process is fair and that the board members are representative of the community. In July 1999, the new Insurance Commissioner, William Kirven III, approved the changes to the by-laws. In contrast to the original process in 1998, Kirven approved these changes without any public hearings or notice.

Consumer groups questioned Kirven's decision and called for a public process. In response to consumer concerns, Kirven scheduled a hearing for September 1st to re-examine his decision. After the hearing, the consumer groups, the Governor's office and the foundation reached a settlement on the foundation by-laws. The new by-laws call for a seven member Community Advisory Committee appointed by the Board of Directors. The CAC is responsible for nominating three people for any Board of Directors vacancy. The Governor appoints Board of Directors members from the list the CAC provides. The Governor may remove a director he or she appointed for cause only. A vote of ¾ of the directors can be used to remove any director with or without cause. The Board of Directors shall have at least one public meeting annually, where the public can address the board.

In August 1999, Health Care Service Corp., which owns BCBS of Illinois and BCBS of Texas, made a bid to buy BCBSCO, and promised $155 million to the foundation. Anthem increased its bid from $140 million, and offered $160 million if BCBSCO agreed to stop considering any other offers. BCBSCO did not agree to stop reviewing other offers, but it did accept Anthem's match of $155 million and rejected Health Care Service Corp.'s bid.

In November 1999, after a 2-day hearing in October, Kirven approved BCBSCO's proposed conversion and sale to Anthem. Anthem placed $155 million in the Caring for Colorado Foundation, $55 million more than it had originally proposed.

Consumer groups appealed the final decision, asserting that Anthem's willingness to pay $160 million if BCBS agreed to stop reviewing competing offers indicates the true full fair market value is equal to $160 million. The Colorado Court of Appeals ruled against the consumer groups and the groups petitioned the Supreme Court of Colorado for a writ of certioriari. In 2001, the Supreme Court denied the petition.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem's home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem

launched its IPO to become a publicly traded for-profit company. [See also Connecticut, Indiana, Kentucky, Kansas, Maine, Nevada, New Hampshire and Ohio].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

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Connecticut

Since 1984, BCBS of Connecticut (BCBSCT) had been a mutual insurer with a certificate of incorporation stating that it was to be operated exclusively for the social welfare of Connecticut residents. (BCBSCT previously was a nonprofit health services corporation.) In July 1997, the Department of Insurance approved the merger of BCBSCT with Anthem Insurance Companies, a for-profit mutual insurance company. The Attorney General recused his office from dealing with the charitable trust issues raised in the merger, citing past assistance BCBSCT provided his office in its tobacco litigation. A Hartford law firm was named Special Attorney General.

During 1997, the state Comptroller and a coalition of advocacy and labor organizations filed separate suits against Anthem to protect policyholder rights and preserve charitable assets now possessed by Anthem. In December 1997, the Special Attorney General filed a suit to prevent Anthem from acquiring and transferring out of Connecticut assets that are rightfully subject to a charitable trust. The Special Attorney General also alleged that Anthem and BCBSCT breached their fiduciary duties by refusing to maintain the assets of the BCBSCT plan for charitable purposes. After the lawsuit was filed, Anthem initiated a public relations campaign against the Attorney General. [See also Kentucky below.] Consumer groups, legislators and the Attorney General denounced Anthem's advertising tactics.

In June 1999, the Attorney General, Comptroller and advocacy groups announced that they had reached a settlement with Anthem. Anthem agreed to transfer approximately $41 million to a foundation to serve the underserved and uninsured as a condition of the settlement. In order to ensure solid community and consumer representation the state established the Connecticut Health Advancement and Research Trust (CHART). This organization proceeded to appoint the board of the Anthem Foundation of Connecticut. The Foundation was incorporated as a supporting organization to CHART.

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Delaware

In 1996, New Jersey BCBS (BCBSNJ) announced that it was proposing to merge with Delaware BCBS (BCBSD). Under the proposal, BCBSNJ would have paid $5 million to buy BCBSD's existing for-profit subsidiary, AllNation, Inc., which held all of BCBSD's business operations. The nonprofit BCBSD, to be renamed the Center for HealthCare Economics, would have retained $103 million from the transaction to provide comparative information on health services and plans. But in August of 1996, a month before the deal was to close, the Department of Insurance put the deal on hold because of concerns about undervaluation and what the proceeds would fund. By April 1997, BCBSNJ and BCBSD called off their deal citing legal and regulatory hurdles in both states.

In December 1998, CareFirst, the holding company that owns the District of Columbia and Maryland BCBS plans, announced that it planned to affiliate with BCBSD. [See District of Columbia and Maryland below.] During 1999, the Department of Insurance and the Solicitor General conducted a review of the proposed combination. The regulators expressed several concerns about the proposed deal, including the transfer of BCBSD assets across state lines, the size of some severance packages for BCBSD executives, and the potential impact of a future CareFirst conversion on policyholders and the community. In late November 1999, the Insurance Department conducted two days of hearings on the proposed combination.

In January 2000, the hearing officer issued her findings. Key recommendations included that BCBSD be required to maintain its nonprofit status for a period of two years, and that BCBSD agree to a "snapshot" valuation to enable Delaware regulators to facilitate the transfer of nonprofit

assets, should BCBSD convert in the future. The Delaware Insurance Commissioner approved the affiliation in March 2000. In her order, she adopted many of the hearing officer's suggested recommendations, and augmented others to give both her office and the Attorney General's office clearer oversight over future activities of CareFirst-BCBSD.

On January 11, 2002, CareFirst filed an application with the Insurance Commissioner to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, Blue Cross and Blue Shield of Georgia and Blue Cross of Wisconsin. The application for conversion was filed in Maryland, Delaware, Virginia and the District of Columbia with the understanding that all three Insurance Commissioners must approve the merger before it can go through. A hearing officer appointed by the Insurance Commissioner will review this application.

Because there had been rumors of this conversion since February 2001, in the 2002 legislative session, both the Delaware Attorney General and the Governor filed legislation seeking to establish a conversion law. Neither bill passed the legislature in 2002 but conversion legislation supported by a consumer coalition and similar to the AG's bill was refiled in 2003 to be considered during the 2003/2004 legislative session.

Following the Maryland Insurance Commissioner's decision in March 2003 [see Maryland] to deny the conversion of CareFirst, WellPoint withdrew its application. In addition, following the passage of the legislation in Maryland to make CareFirst a more responsive nonprofit [see Maryland], BCBSDE expressed its disagreement with this legislation. As a result, BCBSDE negotiated with both Carefirst and the Commissioner to change its affiliation with Carefirst to allow BCBSDE to reestablish control of its plan and its board. This change in affiliation is BCBSDE's attempt to shield itself from the requirements of the new Maryland law including the moratorium on conversion. As part of the change, BCBSDE received its own separate license from the Blue Cross Blue Shield Association.

District of Columbia

In mid-January 1997, Group Hospitalization and Medical Services, Inc. (GHMSI), the Blue Cross and Blue Shield plan for the District of Columbia, announced that it would merge operations with BCBS of Maryland (BCBSMD). Like many BCBS plans around the country, GHMSI was created in the late 1930's as a "charitable and benevolent corporation." Unlike other Blues plans, however, GHMSI was created by Congress and is governed by a federal charter. GHMSI sought to repeal its federal charter, and instead allow the nonprofit to be subject to the D.C. nonprofit code and other health insurance laws.

After much public pressure, however, GHMSI halted its efforts to repeal its federal charter. Instead, it began to pursue modifications to the federal charter so that it could merge with BCBSMD and establish a nonprofit holding company. The modifications declare that GHMSI is a "charitable and benevolent" organization. In December 1997, the Insurance Commissioners of D.C. and Maryland issued formal rulings on the proposed merger. Though falling short of calling for a stipulation by the two Plans that their assets are charitable, both rulings include provisions for the protection of assets. The D.C. ruling in particular re-emphasizes the charitable and benevolent status of GHMSI. The Maryland Insurance Commissioner also required that BCBSMD's public assets be distributed in accordance with Maryland nonprofit law in the event of its dissolution, and required a financial "snapshot" of BCBSMD. In January 1998, the combination of BCBSMD and GHMSI was completed. The Maryland-based nonprofit holding company that governs both Plans is called CareFirst, Inc..

In March 2000, CareFirst "affiliated" with nonprofit Blue Cross and Blue Shield of Delaware. [See Delaware above.]

In January 2002, CareFirst filed an application with the Insurance Commissioner to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, and Blue Cross and Blue Shield of Georgia. The application for conversion was filed in Maryland, Delaware and the District of Columbia with the understanding that all three Insurance Commissioners had to approve the merger in order for it to go forward. A community coalition, CareFirst Watch, monitored the progress of the conversion and reviewed the application. The CareFirst Watch coalition conducted its own valuation and health impact studies to determine what the true value of CareFirst would be if it were sold, and how the proposed transaction would have likely impacted D.C. residents and their ability to access quality affordable health care. [See also Virginia, Delaware and Maryland.]

As part of his review of the CareFirst proposal, D.C. Insurance Commissioner Lawrence Mirel held two public forums in May 2002. Similarly, in September 2002, the Office of the Corporation Counsel ("OCC") held two public forums. In July 2002, the D.C. Council voted on emergency legislation and new protections were won for the District's health consumers including: a shift in the burden of proof to the applicant to demonstrate that the conversion is in the public interest, expanded opportunities for interested individuals and organizations to participate in the Insurance Commissioner's formal hearings, and a 120 day (expanded from 30 days) review period for the Commissioner to decide on an application for conversion.

On March 5, 2003, Maryland's Insurance Commissioner Steven Larsen announced his decision to deny the proposed transaction. D.C. Commissioner Mirel immediately issued a press release stating his plans to similarly deny the proposal in D.C. barring a challenge to Larsen's decision from the Maryland legislature. A subsequent press release stated that WellPoint requested that D.C. stop its review process for 30 days, which would allow the applicant an opportunity to decide its next steps. D.C. agreed to the request.

The Maryland legislature later voiced its approval of Larsen's denial and took steps to introduce new law that would remove 10 of the 21 present Board members of CareFirst for failing in their duties to the non-profit corporation by pursuing the conversion and sale. D.C. Commissioner Mirel publicly challenged the removal of the Board members and appealed to the Maryland Governor, Robert Ehrlich, to veto the bill. In April 2003, the Maryland legislature passed the new law intended to hold CareFirst more accountable to its original non-profit mission, despite the opposition from the D.C. Insurance Commissioner. [See Maryland for details on the law.]

Although no formal public announcement was ever made, the D.C. Insurance Commissioner's office says that the conversion proposal by CareFirst was withdrawn sometime in the fall of 2003. As of March 2004, the D.C. Commissioner has requested that the Maryland legislature make certain changes to the new law and is waiting to hear from Maryland's legislature if these changes have been made before next steps are considered. According to Commissioner Mirel, the new Maryland law, as it currently exists, violates the affiliation agreement between the two health plans and could cause D.C. to seek a disaffiliation from the Maryland plan if the Commissioner's concerns are not appropriately addressed.

Georgia

In May 1996, Georgia BCBS (BCBSGA) filed for conversion and established itself as a privately held for-profit company called Cerulean Companies, Inc. The transaction was approved without any assessment of the plan's charitable trust obligations. In September 1997, nine consumer organizations filed a class action lawsuit and administrative petition against the Georgia Commissioner of Insurance and Cerulean/BCBSGA, alleging that a statute permitting its conversion was unconstitutional, that the approval must therefore be voided, and that the assets of the plan belong to a charitable foundation.

In July 1998, the plaintiffs and Cerulean/BCBSGA reached a settlement. The settlement calls for the transfer of between $70 million and $80 million to a new charitable foundation. The new foundation's board will include three appointees chosen by the plaintiffs, three chosen by Cerulean/BCBSGA, and three designated by prominent Georgia nonprofit organizations. Also on July 8th, Cerulean/BCBSGA announced that it would be purchased by WellPoint Health Networks, Inc., the for-profit successor to Blue Cross of California. The settlement agreement was approved in August 1998.

When the conversion took place in 1996, shares of stock in Cerulean were issued to BCBSGA policyholders who responded to an offer. Subsequent to the announcement of WellPoint's plan to acquire Cerulean, a lawsuit was filed on behalf of the remaining BCBSGA policyholders who did not obtain Cerulean stock. Although implementation of the settlement was delayed because of the policyholders' litigation, in November 2000, the Cerulean board accepted a higher offer from WellPoint. In March 2001, the Georgia Insurance Commissioner approved the acquisition. The acquisition increased the new foundation's endowment to $124 million.

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Idaho

1) In May 1997, WellPoint Health Networks, Inc. announced the creation of a joint venture with Blue Cross of Idaho to form the Idaho Benefits Administration (IBA). Through the IBA, the two companies launched a new dental plan to consumers. According to a press release, the venture is in part designed to increase the ability of businesses to access regional coverage for their employees. WellPoint Health Networks is the for-profit company created from the conversion of Blue Cross of California.

2) In March 2001, Regence Blue Cross Blue Shield of Oregon, Regence Blue Shield of Washington, Regence Blue Cross Blue Shield of Utah, and Regence Blue Shield of Idaho, known as The Regence Group, filed an application to "affiliate" with the Blue Cross and Blue Shield plans in Illinois and Texas, which are divisions of the Chicago-based Health Care Service Corporation (HCSC). [See Illinois]

Illinois

Several years ago, Illinois BCBS (BCBSIL) and Texas BCBS (BCBSTX) submitted proposals to merge. BCBSIL is a mutual insurance company that can become for-profit by a vote of a majority

of its board, while BCBSTX was a nonprofit health services corporation. The Texas Attorney General filed a lawsuit to block the proposed merger in1996, arguing that the proposed merger violated Texas law because the Illinois company did not meet the Texas definition of a “nonprofit.” In 1998, the trial court issued a letter opinion against the Attorney General and in favor of the merger. The court held, contrary to much of the evidence before it, that BCBSTX is not a charitable corporation and that BCBSIL meets the Texas definition of a nonprofit corporation.

In 1998, BCBSIL pleaded guilty to Medicare fraud charges for the years 1985 through 1994 and agreed to pay $144 million in fines to the federal government, the largest penalty assessed against a Medicare claims processor for fraud. As a result of its fraudulent activities, BCBSIL received $1.29 million in undeserved bonuses.

Also in 1998, the Texas Attorney General agreed not to appeal the issue of whether BCBSIL met the Texas definition of a nonprofit corporation and allowed the merger to move forward. In exchange, BCBSIL agreed to pay $10 million over five years to Texas Healthy Kids Corporation (to use for subsidies to low-income families buying insurance for their children). The merger was approved by the Insurance Departments of both Texas and Illinois in late 1998 and has now been consummated.

Health Care Service Corporation (HCSC), the Illinois company that operates the plans in Illinois and Texas (and New Mexico, see below), remains unwilling to admit that the BCBSTX had a charitable asset obligation to the people of Texas. But in December 2002, HCSC entered into a settlement agreement with the Attorney General of Illinois, under which it set aside $124.6 million in a health care foundation, as a result of the transaction in Illinois.

The Texas Attorney General appealed the trial court ruling that BCBSTX was not a charitable organization. In 2003, the Court of Appeals for the Third Judicial District upheld the trial court’s ruling. Weeks later, the Attorney General discovered and shared with the Court of Appeals a written history, which was authorized, underwritten, and published by BCBSTX, entitled Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas (1999). In it, the author stated that BCBSTX had, in fact, solicited and received charitable donations over the years. Because of the new evidence, the Attorney General asked the Court of Appeals to reconsider its affirmation of the trial court’s ruling, which the Court refused to do. In early 2004, the Attorney General filed a petition for review of this matter with the Supreme Court of Texas. A decision by this Court is expected by summer 2004.

HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001. [See New Mexico below.] Also in 2001, HCSC filed an application with regulators in six states to “affiliate” with Blues plans in Oregon, Washington, Idaho and Utah. However, one week before public hearings were to begin on this proposal, HCSC announced it was withdrawing its application.

Indiana

Indiana Blue Cross and Indiana Blue Shield were created in the 1940s. In 1985, the two plans merged and changed their name to Associated Insurance Companies, Inc. In 1989, Associated created a wholly-owned subsidiary, Accordia, Inc., to handle insurance brokerage, claims administration, underwriting management and employee benefit consulting services. Associated conducted an initial public offering of Accordia stock in 1992 and in 1996, the name was changed to Anthem Insurance Companies. Anthem, a mutual insurance company, has purchased BCBS plans in Colorado, Connecticut, Kentucky, Maine, Nevada, New Hampshire and Ohio.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation (“demutualization”), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine,

Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem's home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company. [See also Colorado, Connecticut, Kentucky, Kansas, Maine, Nevada, New Hampshire and Ohio].

In July 2002, the Virginia State Corporation Commission approved the sale of Trigon Healthcare to Anthem Insurance Company for $3.5 billion. The Corporation Commission did require, in their decision, that Anthem maintain certain services locally in Virginia as well as retain a licensed Virginia medical director for entities conducting utilization review for Trigon.

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Kansas

In fall 1996, BCBS of Kansas (BCBSK) proposed a merger with Missouri's BCBS of Kansas City (BCBS-KC). BCBSK had been a mutual insurance company since 1992; prior to that BCBSK had been a nonprofit corporation. BCBS-KC is a nonprofit corporation. In March 1997, BCBSK called off the planned merger after the Attorneys General of Kansas and Missouri questioned the legality of the proposed combination. Among the most contentious issues were whether either plan possessed assets impressed with a charitable trust.

BCBSK then filed a lawsuit against the Kansas Attorney General seeking a declaration that the plan had no charitable trust obligation to the people of Kansas. The Attorney General responded by filing a counterclaim alleging in part that the board of BCBSK breached its fiduciary duty by using substantial corporate assets in its attempt to merge with BCBS-KC. The counterclaim also asserted that some or all of BCBSK's assets were impressed with a charitable trust. BCBSK filed a motion to dismiss the Attorney General's counterclaim, asserting that only the Commissioner of Insurance had jurisdiction to raise those issues. In January 1998, the court ruled in favor of the Kansas Attorney General, denying the motion to dismiss and holding that the Attorney General

had a right to enforce charitable obligations and seek damages against BCBSK if she prevailed in the case. The Kansas Commissioner of Insurance intervened in the case in support of the Attorney General.

In January 2000, shortly before the trial was to begin, the court issued summary judgment rulings. In one ruling, the court found that BCBSK possessed charitable assets from its inception in the early 1940's through 1969, the year the Kansas legislature repealed the enabling statutes that created Blue Cross and Blue Shield. BCBSK then asked the court to reconsider that decision and to clarify some aspects of it. In April 2000, the court rejected BCBSK's motion to reconsider, and in response to the motion to clarify ruled that the 1969 "assets" referred to in the court's January order were net assets only, not all of the company's assets.

In August 2000, the Attorney General, the Insurance Commissioner and BCBSK reached a settlement that placed $75 million into the Sunflower Foundation, a new foundation dedicated to serving the health needs of Kansans, including providing health care to indigent and uninsured persons. Although original reactions to the settlement were very positive, consumer groups questioned the Kansas AG's subsequent decisions in establishing the foundation. Rather than forming an independent foundation, the AG's office established the foundation as a supporting organization to the Kansas AG's office, an unprecedented move. This raised concerns among local advocates that the foundation may be vulnerable to undue political influence in the future. Despite these concerns, the foundation's Articles of Incorporation and Bylaws were approved by the Kansas Secretary of State's office and a nine-member Board of Trustees was named in December 2000.

In spring 2001, members of the state legislature voiced their disapproval of the Attorney General's role in crafting the settlement with BCBSK and establishing the foundation. Although the Kansas press reported that state legislators were considering challenging the Attorney General in the state Supreme Court for overreaching her authority, the only formal action taken was to consider a bill that included an amendment that specifically applied the Kansas Open Records Act to the Sunflower Foundation. In August 2001, an Executive Director was named to the Foundation and in November the Community Advisory Committee was appointed.

In May 2001, BCBSK and Anthem Insurance Companies, Inc., an Indiana-based mutual insurance company that was in the process of converting to for-profit, jointly announced their intent to affiliate. In this transaction, described as a "sponsored demutualization," Anthem planned to provide $370 million to BCBSK, of which $190 million was to cover BCBSK's outstanding expenses and $180 million would have been paid to eligible policyholders. BCBSK would then become a wholly-owned subsidiary of Anthem.

Under Kansas statute, the Insurance Commissioner was responsible for reviewing the proposed transaction. During the review process the Commissioner served as an impartial adjudicator and a testimonial team, comprising Insurance Department staff and outside counsel, was created to review the terms of the deal on behalf of the people of Kansas. The Commissioner's role included presiding over the proceedings, examining the information assembled during the review process and then making a determination whether to approve or reject the proposed transaction. The information gathering process was conducted from September 2001 to January 2002 and included five public comment meetings held in various locations across the state, and three days of formal public hearings.

Concerned about the impact on health services and access, the Kansas Association for the Medically Underserved, the Kansas State Nurses Association, the Kansas Medical Society and the Kansas Hospital Association petitioned for and were granted intervenor status in the proceedings. Over 1,200 Kansans attended the meetings to question various aspects of the deal,

including whether the conversion would benefit them and the lack of objective information available on the deal.

The testimonial team and intervenors called on independent financial and economic experts to help analyze the benefits and detriments of the deal. Chief among the detriments was an analysis of the Kansas insurance environment by PricewaterhouseCoopers, which found that imposing a shareholder profit requirement on Kansas's largest insurer would likely result in additional premium increases in the small and individual group markets of $248 million over five years. In the final hours before the public record was closed, Anthem added to the terms of the deal a $25 million rate stabilization fund that the state could use to subsidize premiums for small group policies payable to Anthem. In January 2002 the eligible policyholders approved the conversion with a vote of 63% to 37%. However, only 58% of the approximately 172,000 eligible policyholders voted.

Also in January 2002, the testimonial team joined the four intervenors in formally opposing the transaction. Citing the additional premium increases, the testimonial team's report recommended rejecting the conversion proposal and took particular exception to Anthem's last minute offer of $25 million calling it, "an insult to the intelligence of [Kansans] and the Commissioner."

In February 2002, the Insurance Commissioner formally rejected the proposed conversion in her Final Order and became the first industry regulator in the nation to reject a for-profit health insurer's proposal to buy a state's Blue Cross and Blue Shield Plan. The executive summary of the final order stated that the deal was rejected because it was found to be, "unreasonable to policyholders and not in the public interest, and hazardous and prejudicial to the insurance-buying public." On February 19, BCBSK announced that it would appeal the Commissioner's final order and formally began the appeals process.

In June 2002, Judge Terry Bullock of the Shawnee County District Court issued a Memorandum Order and Decision vacating Sebelius's Final Order and remanding the case back to her for further proceedings consistent with the ruling. In his ruling, Bullock concluded that Sebelius had exceeded her authority when she disapproved the proposed transaction because she is not authorized to take such regulatory action based upon anticipated premium rates or surplus levels that satisfy the requirements of some section of the Kansas Insurance Code.

Undeterred by Bullock's decision, Sebelius issued a written statement in which she promised "to protect the families and businesses of Kansas from millions of dollars in increased insurance rates." Making good on this vow, Sebelius filed a Notice of Appeal in June 2002 arguing that it was within her statutorily-granted authority to disapprove the proposal as she did. Anthem and BCBSKS also appealed Judge Bullock's decision arguing that Bullock should not have remanded the case back to Sebelius, but should have ordered her to allow the sponsored demutualization. After Sebelius requested that the case be heard in the Kansas Supreme Court, the Kansas Supreme Court agreed to the transfer and heard the appeal in March 2003. In August 2003, the Kansas Supreme Court upheld Sebelius's decision to deny the proposed sale of BCBSK to Anthem Insurance.

Kentucky

Kentucky BCBS (BCBSKY) became a mutual insurance company in 1987 but retained its nonprofit purposes. Prior to 1987 it was a nonprofit health services corporation. In 1993, it merged with Anthem Insurance Companies, Inc., a for-profit mutual insurance company. The Department of Insurance approved the merger without any consideration of BCBSKY's charitable assets. In 1996, the Department of Insurance requested that the Attorney General's office seek an audit of the 1993 merger because a routine investigation by the Department had raised questions about Anthem's use of reserves. In March 1997, Anthem filed a lawsuit against the

Attorney General and the Department of Insurance, alleging that the merger investigation exceeded the regulators' scope of authority.

In October 1997, the Attorney General filed a lawsuit against Anthem seeking to recover millions of dollars in charitable assets that Anthem absorbed when it merged with BCBSKY, and to reimburse policyholders for premium increases due to violations of the Consumer Protection Act. Two days later, Anthem initiated a public relations campaign against the Attorney General's lawsuit and consumer groups by sending a mailing to all of its policyholders in Kentucky and taking out advertisements threatening higher premiums and less financial security if the Attorney General prevailed. [Anthem's public relations campaign was replicated in Connecticut.] In March 1998, the Commissioner of Insurance ruled that Anthem conducted a "highly misleading" campaign, but decided to take no action against Anthem.

In 1998, the trial court dismissed the Attorney General's Consumer Protection Act claims. He appealed that ruling. In April 1999, a unanimous appellate court reversed the trial court's dismissal and ruled that the Attorney General should have the opportunity to investigate and bring to trial the consumer protection claims against Anthem.

In the meantime, in June 1998, Anthem filed a motion for summary judgment, which asked the trial court to dismiss the charitable trust claims without a trial. The Attorney General opposed the motion. Consumer groups filed three "friend of the court" briefs supporting the Attorney General's arguments. Anthem opposed the three briefs and asked the trial court judge not to consider them. In November 1998, the trial judge ruled against Anthem and accepted all three "friend of the court" briefs because they provided information that could be useful in reaching a decision in the case.

In March 1999, the trial court held a hearing on Anthem's motion for summary judgment on the charitable trust claims, and in May 1999, the court denied the motion. The trial court's decision allowed the case to proceed, and gave the Attorney General the opportunity to prove that BCBSKY held charitable assets and to determine the value of those assets.

In December 1999, the Attorney General and Anthem announced a settlement of the charitable trust issue. Anthem has agreed to place $45 million into a newly created 501(c)(3) foundation that would be used to fund unmet health care needs of Kentuckians. During the interim period, the $45 million is being held in an interest bearing state governmental trust account. The members of the Advisory Board will be appointed by the Franklin Circuit Court upon nomination by the Attorney General and will be charged with making recommendations to the Court about the structure and composition of the new foundation.

In September 2000, Governor Patton appointed a 35-member advisory committee from over 80 people who were nominated. The advisory committee is diverse both geographically and demographically. It includes individuals from universities, provider groups, businesses, and philanthropies, with no single interest appearing to dominate. Among the groups represented on the committee are consumer groups who were deeply concerned about the potential loss of charitable asset dollars when Kentucky Blue Cross merged with Anthem. The advisory committee was set up to establish a foundation.

Initially, the advisory committee met in December 2000 to discuss key elements of the structure and composition of the new health foundation, including its articles of incorporation, by-laws, a nomination process and an initial slate of Board members. Early in 2001, the Franklin Circuit Court approved the advisory committee's articles of incorporation and bylaws to establish the Foundation for a Healthy Kentucky, Inc. Among the characteristics of the Foundation is an important role for a continuing Community Advisory Committee that will have as its members

many of the individuals who served on the advisory committee. The new foundation has received the $45 million in charitable assets recovered in the Anthem settlement, plus interest.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation (“demutualization”), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem’s home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company. [See also Colorado, Connecticut, Kentucky, Kansas, Maine, Nevada, New Hampshire and Ohio].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation’s largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that “the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans’ focus from meeting community needs to meeting needs of Wall Street.”

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

Maine

In 1996, BCBS of Maine (BCBSME) proposed joint ventures with two nonprofit hospitals in Maine in order to establish for-profit HMOs. Before the Superintendent of Insurance issued a decision on the proposed joint ventures, BCBSME and the Attorney General announced that they had reached an "agreement in principle" on BCBSME's charitable status. The agreement between BCBSME and the Attorney General included legislation that required a charitable set-aside in the event of an outright sale to a for-profit corporation. Unfortunately, the legislation also had several shortcomings. It allowed BCBSME to transfer some of its fair market value to its subscribers upon conversion, even though it is not and has never been a mutual corporation. It also contains a very narrow definition of conversion that does not encompass many transactions that would allow a nonprofit corporation to convert to for-profit status. Finally, it expressly authorizes a nonprofit health service corporation to create a for-profit subsidiary, called a health insurance affiliate, by using a material or substantial amount of the nonprofit corporation's assets.

In July 1999, BCBSME and Anthem Insurance Companies announced plans to "affiliate." The terms of the proposed agreement included a purchase price of $120 million and a foundation with

assets valued at $90-$100 billion. In August 1999, consumer groups met with representatives of the Maine Attorney General's office to begin a dialogue about the structure of the foundation. Under the Blue Cross conversion law, the Attorney General must approve, disapprove, or modify the charitable trust plan before the Insurance Commissioner can examine other aspects of the transaction.

Over the course of the Attorney General's review of the charitable trust plan, a large coalition formed to represent individuals and organizations concerned with the proposed sale. The Attorney General held a series of 12 public forums throughout the state in late 1999 to solicit comment on the mission, governance and structure of the proposed foundation. Following these public meetings and discussions with public interest groups, the Attorney General submitted his modifications to the foundation plan prepared by BCBSME. The Kennebec County Superior Court approved the modified foundation plan in December 1999. This plan established the mission of the new foundation ("to foster improved access to health care and improved quality of health care to medically uninsured and medically underserved persons within the State of Maine…") and ensured that at least 3 members of the governing board represent the interests of medically uninsured and underserved populations of the State. The plan also established a community advisory committee that will oversee required periodic needs assessments and be represented on the nominating committee to fill seats on the foundation board.

The Superintendent of Insurance held a public meeting in January 2000 and evidentiary hearings in April 2000. A key member of this coalition, Consumers for Affordable Health Care (CAHC), was granted intervenor status in the insurance department proceedings. CAHC participated in the evidentiary hearings.

A number of consumer and advocacy groups, including CAHC, opposed the sale. Their reasons for opposing the sale include that fact that Anthem will be acquiring BCBSME's growing market share in the state at a reduced price. As a result of the liquidation of Tufts' Health Plan and the precarious state of Harvard Pilgrim Health Care, BCBSME's membership has increased by over 60,000 since this summer. BCBSME was also recently awarded a sizable state contract.

The Superintendent approved the deal on May 25, 2000. In his order, the Superintendent accepted the valuation performed in July of 1999 that fixed BCBSME’s fair market value at $102.5 million. He then deducted $18.1 million in 1999 losses and $3.9 million in transaction expenses, leaving only $80.5 million for the resulting foundation. (Anthem has also agreed to include an extra $1.2 million to the resulting foundation.) In June 2000, both the Attorney General (AG) and CAHC appealed the Superintendent’s Order, challenging his valuation of the fair market value of the plan. In the meantime, the Attorney General named an 18-member community advisory committee, which submitted nominations for the 15-member Board of Trustees. The Attorney General appointed the members of the initial Board in December 2000.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation (“demutualization”), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem’s home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company. [See also Colorado, Connecticut, Indiana, Kentucky, Kansas, Nevada, New Hampshire and Ohio].

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In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

Maryland

In 1994, BCBS of Maryland (BCBSMD) proposed to convert from a nonprofit health services corporation to a for-profit stock insurance company. The plan characterized its proposal as a "restructuring." The proposal included financial incentives for executives, including stock options, and ignored the plan's charitable purposes. In January 1995, the Maryland Commissioner of Insurance rejected the proposal. BCBSMD then lobbied for legislation that would permit it to convert, but the legislation failed. Subsequently in mid-January 1997, BCBSMD announced that it would merge with Group Hospitalization and Medical Services, Inc. (GHMSI) of the District of Columbia. The merger was completed on January 16, 1998. The Maryland-based nonprofit holding company that governs both plans is called CareFirst, Inc. [See District of Columbia above for more information on the merger.]

In April 1998, the Governor of Maryland signed conversion legislation giving the Commissioner of Insurance the authority to require a set-aside of all "public or charitable" assets possessed by health service plans such as BCBSMD. The legislation established in statute a conversion foundation, the Maryland Health Care Foundation, to protect the charitable assets.

In March 2000, CareFirst "affiliated" with nonprofit Blue Cross and Blue Shield of Delaware. [See Delaware above.]

In January 2002, CareFirst filed an application with the Insurance Commissioners of Delaware, Maryland and the District of Columbia to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, and Blue Cross and Blue Shield of Georgia. All three Insurance Commissioners had to approve the merger in order for it to go forward.

Anticipating the CareFirst conversion, the Maryland Legislature amended the state's conversion law in April 2001. This amendment requires that the conversion assets be preserved in a trust within the existing conversion foundation to be expended only at the direction of the state legislature. The legislative session of 2002 ended with the passage of two very significant bills that created more stringent requirements for conversions including a shift in the burden of proof to the applicant to demonstrate that the conversion is in the public interest, a requirement that the purchase price be provided to the foundation in cash, and restrictions on compensation packages for executives.

The Insurance Commissioner contracted with four experts to assist him in his review of the application. The valuation experts returned their report on the valuation of CareFirst and advised the commissioner that CareFirst was worth much more than the $1.3 billion purchase price. The Commissioner also contracted with experts to study the due diligence aspect of the transaction, foundation issues, the health